Trinity Life Insurance Company

7633 East 63rd Place, Suite 230
Tulsa, OK 74133
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EPILEPSY (CONVULSIONS) QUESTIONNAIRE – APPLICANT TO COMPLETE

NAME	FILE NUMBER	DATE OF BIRTH

1. Has the doctor given you a name for your seizure disorder? (grand mal epilepsy, petit mal epilepsy, Jacksonian epilepsy, psychomotor or temporal lobe seizures) Does he know the cause?

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2. When did you have your first seizure? Date: ______________________________

3. When was your last seizure? Date: ______________________________

4. How often do you have seizures (number weekly, monthly, yearly)?

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5. If possible, please describe the seizures. Do you have any warning?

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6. What type of treatment? Medications? Hospitalizations?

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7. How long have you been taking medication? Any change in medicine?

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8. Name and address of doctor who treated or is treating you:

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9. Date of last visit?

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DATE: ____________________ ______________________________
Signature of Applicant